(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING HAL034023 07/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2101 HOMESTEAD HILLS DRIVE HOMESTEAD HILLS ASSISTED LIVING WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 Report of a Biennial Construction Survey by Frank Strickland and Ed Miller on 07/29/2015: Based on information gathered from the DHSR database, this facility was either first submitted or licensed for licensure on 01/01/1993. Based on this information, this facility is required to meet the 1991 Rules for the Licensing of Domiciliary Homes (Homes for the Aged and Family Care Homes); the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds; and the 1991 North Carolina State Building Code (1992 Revision), Section 409.1 Group I-Unrestrained Occupancy. FACILITY IS LICENSED FOR 66 BEDS (18 ALZ BEDS). Deficiencies have been cited and a Plan of Correction is required. C 189 Building Equipment Maintained Safe, Operating C 189 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1-Based on observation, the facility has failed to maintain the in a safe operating manner of the Fire Alarm notification components of the system. This would affect all staff and residents by allowing this unsafe condition to persist. Division of Health Service Regulation

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		HAL0340	23	B. WING		07/	29/2015	
	PROVIDER OR SUPPLIER	D LIVING	2101 HON	DRESS, CITY, S MESTEAD HII I SALEM, NO				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE			
C 189	Continued From page 1			C 189				
	Findings on 07/29/2 The AV strobe did r Alarm Test was cor the hall from Room 2-Based on observ maintained in a saf handling portable r could affect all resic cylinder fell, breakn the cylinder into a c	not activate when ducted that is I 308. ation, the facilitie manner by nonedical oxygen dents, stall and ag their valves thangerous projections.	y wast ot properly cylinders. This visitors if a hen propelling ectile.					
	A medium duty M medical oxygen cylinder was stored standing upright and not secured in a rack or dolly that is located in the Oxygen Storage Room in 200 Hall.							
	3-Based on observe maintained in a saft doors from closing smoke and/or fire. residents and staff and/or fire in the control of the saft and saft a	e manner by pr rapidly in order This condition by not containir	reventing fire to contain could affect all ng smoke					
	Findings on 07/29/2 The 1-1/2 hour fire the Kitchen and the the open position.	rated fire door						
	4-Based on observ maintained in a saf through fire-rated c integrity. This could in the event that fire contained in a room	e manner beca onstruction inva d affect all reside and/or smoke	use breaches alidated its dents and staff is not					
	Findings on 07/29/2 The fire sprinkler es		es for the					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
HAL034023		B. WING		07/29/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
HOMES1	EAD HILLS ASSISTE	D LIVING	MESTEAD HI I SALEM, NO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE		
C 189	Continued From page 2		C 189				
		ated in Room 222 and 200 Room behind dryer do not ngs.					
	maintained in a safthrough fire-rated cointegrity. This could in the event that fire	ation, the facility was not e manner because breaches onstruction invalidated its d affect all residents and staff e and/or smoke is not n or compartment of origin.					
	and electrical instal	2015: enetrations due to gas piping lations that are located in the lechnical Rooms that are not					
	maintained in a saf- through fire-rated c integrity. This could in the event that fire	ation, the facility was not e manner because breaches onstruction invalidated its d affect all residents and staff e and/or smoke is not n or compartment of origin.					
	and electrical instal	2015: enetrations due to gas piping lations that are located in the om that are not sealed.					
	doors have not bee	ation, the building exterior n maintained to be easily affect all residents and staff in ergency.					
	the 300 Hall and ad	or that is located at the end of ljacent to Room 318, drags at on the strike side and requires					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		HAL034023	B. WING		07/2	9/2015		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
HOMEST	HOMESTEAD HILLS ASSISTED LIVING 2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
C 189	Continued From pa	ge 3	C 189					
	doors have not bee	ation, the building interior n maintained to maintain affect all residents in periods						
	Findings on 07/29/2 The interior corridor not latch.	2015 : r door for Room 403A does						
	maintained the med	ation, the facility has not chanical ventilation in several lity. This may effect the staff lities.						
	exhausting the inter	2015 ntilation system is not rior air in the Laundry and om that are located in the 300						
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